STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155682	A. BUILDING 00 B. WING	05/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODMONT HEALTH CAMPUS	1325 ROCKPORT RD BOONVILLE, IN47601

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F0000	This visit was for a Recertification and State Licensure survey. Survey dates: May 09, 10, 11, 12, 13, 16, 17, 18, 2011 Facility number: 002724 Provider number: 155682 AIM number: 200309330 Survey team: Carole McDaniel, RN TC Terri Walters, RN Elizabeth Harper, RN Census bed type: SNF/NF: 6 SNF: 15 NF: 27 Residential: 30 Total: 78 Census payor type: Medicare: 15 Medicaid: 27 Other: 36 Total: 78 Sample: 12 Residential sample: 7 These deficiencies also reflect State	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	findings cited in accordance with 410 IAC 16.2. Quality review completed on May 24, 2011 by Bev Faulkner, RN			

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F0156 SS=C	The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;			

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	A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.			

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	The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. Based on observation, interview, and record review, the facility failed to clearly display information regarding Medicare and Medicaid information for resident viewing for 48 residents in the population of 48. Findings include: On initial tour of the facility on 5/9/11 at 8:25	F0156	F 156There were no residents affected bythis deficient practice and none thatwere potentially affected.Administrator inserviced onrequirements of the displaying ofMedicare/Medicaid benefits.Completion Date 6/17/11Posting will be in larger font,positioned upright in the corridor of the main entrance.Completion Date 6/17/11QA rounds monthly will include the Medicare/Medicaid beingposted and in required format x12months.	06/17/2011

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	A.M., facility documentation (What is Medicare and What is Medicaid) was observed in a white plastic notebook laying flat on a table to the right in the facility lobby. The notebook cover had small typed print which included information regarding Medicare and Medicaid but was not easily visible for reading. The notebook with the Medicare and Medicaid information remained in a flat position not easily visible for reading on 5/10/11, 5/11/11,			

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	5/12/11, and on 5/13/11 until the Administrator was notified on 5/13/11 at 11:10 A.M. On 5/13/11 at 11:20 A.M., the Administrator was made aware of facility information regarding Medicare and Medicaid was not clearly displayed for resident viewing. The Administrator indicated the information will be made available. 3.1-4(l)(1)			

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F0164 SS=E	The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. Based on observation and interview, the facility failed to ensure room doors were closed or privacy curtains were	F0164	F 164Residents #25, #36, #39 and #48suffered no ill effects from the alleged deficient practice andthrough corrective action and inservicing will ensure residents privacy is maintained.Completion Date 6/17/11All residents have the potential to be affected and therefore through alterations in provision of care andinservicing will ensure that privacy is	06/17/2011

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	pulled during care and treatments for 4 of 8 residents receiving treatments or care from a sample of 12. Resident # 25, # 36, # 39 and # 48 Findings include: 1. During observation on 5/11/11 at 11:30 A.M., Resident # 39 was taken from the hallway to the shower room by RN # 3. In the shower room, the nurse checked the resident's blood sugar and administered insulin. The insulin was administered in the		maintained.Completion Date 6/17/11Systemic change to ensure privacy is maintained during provision of care is to have the door shut and room curtain pulled around the resident and staff will be inserviced oninterpretive guidelines as it relatesto privacy.Completion Date 6/17/11DHS or designee will audit residents receiving care 3/day for 2weeks, then daily for 2 weeks, then3/week for 3 months, 1/weekthereafter wih results of auditsbeing submitted to QA committeemonthly for 6 months and quarterly thereafter.	

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	resident's left lower quadrant of the abdomen. The door to the shower room remained open and there was no privacy curtain pulled to prevent the resident from being viewed from the hallway. 2. On 5/11/11 at 11:47 A.M., Resident # 25 was in her room in the Broda chair, which was positioned at the foot of the beds facing the entry door. RN # 3 was observed to check the resident's blood glucose			

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	and then administered insulin in to the resident's lower left quadrant of the abdomen. The door to the room was open and the resident could be viewed from the hallway. 3. On 5/11/11 at 12:00 P.M., RN # 3 was observed to check the Resident # 36's blood glucose and administer a gastric tube water flush of 250 milliliters of warm water and 20 milliliters of Diet Coke. Resident # 36 was sitting			

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	in his room in his wheelchair facing the foot of the bed where he was able to see out his door. The door to the room was open to the hallway. The privacy curtain was not pulled and remained fastened with a snap to the wall. On 5/13/11 at 11:15 A.M., the Director of Health Services offered no further information regarding privacy during treatments. 4. On 5/11/11 at 11:30 A.M., OT #1 and CNA # 5 were providing perineal care to Resident #48, after an incontinent B.M. The door to the resident's room was closed but the privacy curtain was not drawn around the resident. One of the			

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	staff responded to the knock with "Yes." Upon entry, the resident was exposed and the privacy curtain was not drawn. On 5/18/11 at 1:10 P.M., the Director of Nursing was interviewed regarding privacy concerns above. She indicated from the initial CNA training for certification to the facility orientation the use of privacy curtains and use of doors is stressed and is a performance expectation as for all nursing staff upon which they are evaluated. 3.1-3(p)(2)			
F0167 SS=C	A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. Based on observation,	F0167	F 167There were no residents affected bythis deficient practice	06/17/2011

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	interview, and record review, the facility failed to ensure past federal survey reports were clearly posted for resident viewing for 48 residents in the facility population of 48. Findings include: On initial tour of the facility on 5/9/11 at 8:25 A.M., a white plastic notebook was observed laying in a flat position on a table to the right of the		and none thatwere potentially affected.Administrator inserviced on requirements of the displaying ofsurvey results.Completion Date 6/17/11Posting will be in larger font,positioned upright in the corridor ofthe main entrance.Completion Date 6/17/11QA rounds monthly will include verification that the survey resultsare posted and in required formatx12 months.	

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	facility lobby. The notebook cover had small typed print which included information regarding survey results. The type was small and was not easily visible for reading. This notebook containing survey reports remained on the table in the lobby on 5/9/11, 5/10/11, 5/11/11, 5/12/11, and 5/13/11, until 5/13/11 at 11:10 A.M., when the Administrator was notified of survey			

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	reports not being clearly and easily visible for resident reading. On 5/13/11 at 11:10 A.M., the Administrator was made aware of survey reports not being visible for resident reading/viewing. The Administrator indicated at this time she would make the reports readily visible for residents viewing. 3.1-3(b)(1)			

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F0176 SS=D	An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. Based on observation, interview and record review, the facility failed to complete the Interdisciplinary Team Evaluation for 1 of 1 residents whom self-administered medications from a sample of 12. Resident # 40 Findings include: On 5/10/11 at 8:25 A.M.,	F0176	F 176Resident #40 suffered no ill effectsfrom the alleged deficient practice and through corrective action and inservicing will ensure residents that self administer medication have beenreviewed by interdisciplinary teamand deemed appropriate to do so.Completion Date 6/17/11All residents that self administerhave the potential to be affected and therefore have been assessed by interdisciplinary team to ensure theyare safe to do so and throughеducation/inservicing will ensurethat residents are reviewed by theteam prior to being allowed to do so.Completion Date 6/17/11Systemic change will includeinterdisciplinary team education/inservice on interpretiveguidelines as it relates to self administering medication.Completion Date 6/17/11DHS/designee will ensure thatresidents are assessed byinterdisciplinary team when order isreceived to self administer medication and quarterly thereafteror with any significant changes.Completion Date 6/17/11A list of those that self	06/17/2011

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	during observation of the medication pass by RN # 3, it was indicated Resident # 40 had an order to administer her own eye drops. The physicians order, dated 01/31/11, read: "Systane Lub Eye Drop 15 ml (milliliter), instill 1 drop in both eyes 2 times a day as needed for dry eyes **MKAB** [may keep at bedside]." An interview at this time with RN # 3 indicated Resident # 40 had an order to self administer the eye drops. In interview with Resident		administertheir medications and the current assessment will be submitted to QA committee monthly for 12months for review and further recommendations.	

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	# 40 at this time, she indicated she instills her drops 3 or 4 times a day. On 5/10/11 at 9:00 P.M., the record review indicated the "Assessment for Self-Administration of Medications," dated 1/4/11, was completed by RN # 3. The Interdisciplinary Team Evaluation section was blank. 3.1-11(a)			

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F0221 SS=D	The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Based on observation, record review and interview, the facility failed to ensure restraints were utilized for the least duration of time necessary and with a plan of reduction for 2 of 2 restrained residents in a sample of 12. Resident #8 Resident #43 Findings include: 1. Resident #8 was observed and monitored to be wearing an alarmed seat belt restraint	F0221	F 221Resident #8 suffered no ill effects fromthe alleged deficiency, careplanshave been updated to reflect current restraint release opportunities whenin direct supervision.Completion Date 6/17/11Res #43 suffered no ill effects fromthe alleged deficiency, careplanshave been updated to reflect currentrestraint release opportunities when in direct supervision.Completion Date 6/17/11All residents who require restraintshave the potential to be affected bythe alleged deficient practice and have been assessed to ensure that ifthey are able to be reduced during direct supervision that the careplan is updated and staff that care for themhave been inserviced.Completion Date 6/17/11Systemic change will includeassessment of resident ability to havedevices removed at various times of the day when in direct supervision of staff.Completion Date 6/17/11Nursing, Therapy and Activity staffinserviced on restraint reductionrepuirements and specifically thoseresidents with restraints that havebeen careplanned for reduction of time in restraint.Completion Date 6/17/11DHS/Designee to audit everyrestraint in use daily x30 days,weekly x5 months and	06/17/2011

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	throughout the directly supervised meals in the Assisted dining room on 5/09/11 at lunch 11:45 A.M., to 12:10 P.M.; on 5/10/11 at breakfast 7:30 A.M., to 9:00 A.M., and on 5/11/11 at supper 4:40 P.M., to 5:00 P.M. Resident #8 was also observed to be restrained with a seat belt restraint throughout direct 1:1 supervision by the Activity Director on 5/10/11 from 1:40 P.M., until 2:45 P.M., at which time she was continuing to be supervised.		monthlythereafter to ensure restraintreduction by means of time out ofrestraint is occurring.Results of audits will be forwarded to QA committee monthly and all restraints will be reviewed by QA committee monthly x6 months and quarterly thereafter for ongoingmonitoring and furtherrecommendations if indicated.	

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	On 5/09/11 at 11:55 A.M.,CNA was interviewed concerning the resident capability of restraint self removal. She indicated "Oh no she can't." On 5/10/11 at 8:55 A.M., the resident was observed up in her wheel chair in the hall working with her restraint fastener but was unable to open it. The clinical record of Resident #8 was reviewed on 5/10/P.M. at 2:00 P.M. Diagnoses included but was not			

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	limited to "Alzheimer's Dementia, Abnormality of gait, Decreased function ability." There was a physician order on 7/06/10 for a self release seat belt on when in wheel chair from 2:00 P.M., until bedtime each night. There was a corresponding 7/06/10 Physical Restraint Consent form. It indicated to family the device was a restraint in that it could "not be easily removed by the resident" and "restricts freedom of movement or access to one's body."			

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	On 12/28/10,the device was ordered increased, to be utilized whenever the resident was in the wheel chair, related to poor safety awareness. The current Care Plan in use from 7/28/10 and last updated 5/01/11, called for release of the restraint with meals, activities of daily living, toileting, and care provisions. Documentation was lacking of a systematic restraint reduction program plan to ensure			

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	the least restrictive device for the least amount of time or supervised trials to ensure restraints continued to be warranted. The Activity Director was interviewed on 5/12/11 at 9:30 A.M., she indicated neither herself nor either of her 2 assistants would remove restraints during direct 1:1 supervision of Resident #8 since they were not authorized to do so. She stated "if we have her longer than 2			

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	hours we would take her to nursing to release her." During interview on 5/12/11 at 9:40 a.m., the Director of Nursing indicated she understood the intention of least restrictive and shortest possible duration of restraint use. She stated specific examples"...like during meals and during 1:1 supervision like in Activities and during increased supervision"they should be removed. She indicated there was no			

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	documentation she could share to show specific restraint reduction plans although it was considered during staff quality assurance meetings. The undated facility Procedure titled "Guidelines for Restraint / Enabler" included the following: "12. If restraints are used there must be a systematic gradual restraint reduction program in place. 13. Remember to use the least restrictive device for the least			

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	amount of time." 2. Resident #43 was observed to be wearing an alarmed seat belt restraint throughout the directly supervised meals in the Assisted dining room on 5/09/11 at lunch 11:45 A.M. to 12:10 P.M.; on 5/10/11 at breakfast 7:30 A.M., to 9:00 A.M., and on 5/11/11 at supper 4:40 P.M., to 5:00 P.M.. The resident was observed in Physical Therapy on 5/10/11 from 8:20 A.M., to 8:40			

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	A.M., during range of motion exercises of the lower extremities. She was attended 1:1 during the exercises and was observed to be restrained with a seat belt, while seated in the wheel chair, throughout the complete series of range of motion. During care observation on 5/09/11 at 11:00 A.M., with CNA #4 and 5/10/11 at 9:30 A.M., with CNA#3 the resident was unable to unfasten the restraint.			

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	The clinical record of Resident # 43 was reviewed on 5/09/11 at 12:30 P.M. Diagnoses included but were not limited to Alzheimer's Dementia and Subarachnoid Hemorrhage. There was a 4/20/11 order for alarmed self-releasing seat belt while in wheel chair due to decreased safety awareness. The 4/20/11 Care plan addressed use of restraint but lacked an intervention or approach			

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	to specifically release restraints with meals, activities of daily living, toileting or care provisions. It directed restraint to be released every 2 hours. Documentation was lacking of any plan of restraint reduction to either a lesser restrictive restraint or less duration of time during which resident was restrained or planned supervised trials to ensure restraint was warranted. 3.1-26(h)			

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	3.1-3(w)			

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F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on interview and record review, the facility failed to ensure	F0225	F 225Res#4 was interviewed ad investigation completed regarding the allegation and found to beclarified as a care concern ondressing procedures and staff thatcare for inserviced her	06/17/2011

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	an allegation of abuse reported by a resident to a staff member was reported to the Administrator and investigated in a timely manner, and reported to the state agency for 1 of 1 resident reported allegations in a sample of 12. Resident #4 Findings include: Resident #4's clinical record was reviewed on 5/9/11 on 11:05 A.M. Her current Minimum Data Set Assessment (MDS), dated 4/8/11,		requestsand procedure of dressing related toshoulder pain.Completion Date 5/11/11There were no other residentsaffected by the deficient practice andthrough inservicing and provision ofreporting instructions will ensure all allegations of abuse are reported toISDH within 24 hours per guideline.Completion Date 6/17/11Management staff and all line staff inserviced regarding investigationprocedures and requirements of reportig all allegations of abuseimmediately to the administrator forcomplance with reportableregulation.Completion Date 6/17/11ED will submit all reportables toQA committee monthly for reviewof compliance with reporting requirements x6 months and quarterly for review and furtherrecommendations.	

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	indicated a score of 15 (cognition intact). On 5/11/11 at 11:20 A.M., after interview with Resident #4, the Administrator was made aware of Resident #4 allegation of two CNAs (CNAs #1 and #2) talking roughly and forcefully at her and of Resident #4 reporting this to RN#1. At this time, the Administrator indicated she was not aware of this allegation. She indicated she would investigate this allegation.			

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	On 5/13/11 at 9:00 A.M., the completed facility investigation report of the above allegation was received and reviewed. Documentation indicated RN #1 had identified Resident #4's concern as a care concern and not as an allegation of abuse. Documentation was also lacking that the state agency had been notified of the resident's allegation of abuse. On 5/13/11 at 9:30 A.M., during interview with the Administrator regarding			

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	the facility investigation of Resident #4's allegation. She indicated she had not reported the allegation to the state agency due to the investigation of the allegation within 24 hours had not determined abuse. 3.1-28(c)			

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F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to follow their abuse policy and procedure for reporting to the Administrator and the state agency alleged allegations of abuse for 1 of 1 resident allegation reported in a sample of 12. Resident #4 Findings included: Resident #4's clinical	F0226	F 226Res #4 was interviewed and investagation completed regardingthe allegation and found to be clarified as a care concern ondressing procedures and staff that care for inserviced on her requestsand procedure of dressing related to shoulder pain.Completion Date 5/11/11There were no other residentsaffected by the deficient practice andthrough inservicing and provision of reporting instuctions will ensure allallegations of abuse are reported to ISDH within 24 hours per guideline.Completion Date 6/17/11Executive Director inserviced regarding investigation proceduresand requirements of reporting allallegations of abuse immediatelyregardless if it is found to be abusewithin 24 hours.Completion Date 6/17/11ED will submit all reportables to QA committee monthly for review of compliance with reportingrequirements x 6 months andquarterly thereafter for review and furtherrecommendations.	06/17/2011

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	record was reviewed on 5/9/11 on 11:05 A.M. Her current Minimum Data Set Assessment (MDS), dated 4/8/11, indicated a score of 15 signifying the resident's cognition to be intact. The facility abuse policy entitled "Prevention and Reporting of Suspected Resident/Patient Abuse and Neglect" (revision date			

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	11/2005) was received from the Administrator on 5/9/11 at 1:00 P.M. The policy included but was not limited to: "... 4. Identification b. Any person with knowledge or suspicion of suspected violations shall report immediately, without fear of reprisal... c. IMMEDIATELY notify the Executive Director, director of Health Services or their designee... d. The Director of Health Services or the			

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	Executive Director is responsible for: Notification to your State Department of Health (per State guidelines) and other agencies, which include the Ombudsman, Adult Protective Services and/or local law enforcement agencies, as indicated." On 5/11/11 at 11:20 A.M., after interview with Resident #4, the Administrator was made aware of			

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	155682	A. BUILDING 00 B. WING	05/18/2011

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	Resident #4 allegation of twp CNAs (CNAs #1 and #2) talking roughly and forcefully at her and of Resident #4 reporting this to RN#1. At this time, the Administrator indicated she was not aware of this allegation. She indicated she would investigate this allegation. On 5/13/11 at 9:00 A.M., the facility investigation of the above allegation was			

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	received and reviewed. Documentation indicated RN #1 had identified Resident #4's concern as a care concern and not an allegation of abuse. Documentation was also lacking that the state agency had been notified of the resident's allegation of abuse. On 5/13/11 at 9:30 A.M., during interview with the Administrator regarding the facility investigation of			

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	Resident #4's allegation. She indicated she had not reported the allegation to the state agency due to the investigation of the allegation within 24 hours had not determined abuse. 3.1-28(a)			
F0241 SS=E	The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation	F0241	F 241Res #55, #56, #58, #60 and #61were assessed to determine	06/17/2011

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	and interview, the facility failed to promote the dignity of residents with prompt attention to toileting needs, assistance with feeding, providing care explanation before onset of care, and providing for social etiquette in group settings (therapy). These deficient practices affected 5 of 7 residents at the Group Meeting (Resident #55 Resident #56 Resident #58 Resident #60 Resident #61), 3 of 3 residents observed to be fed by staff (Resident #25,		identifiedneeds were met and assistance wasoffered and staff that care for theminserviced on their needs.Completion Date 6/17/11All residents who utilize their calllights to communicate their needs forassistance have the potential to beaffected by the alleged deficient practice. Resident Council Presidentestablished an acceptable parameter of minutes as acceptable responsetime.Completion Date 6/17/11Privacy curtain placed in therapy around mat area.Completion Date 5/11/11Systemic changes include in-servicing of all Departments to answer call lights with instructions to find a caregiver within established parameters. In-service includesleaving light on for other departments if it requires a nursing care giver to meet the need. If a caregiver responds to call light theyare instructed to leave light on untilneed is met. Directed inservice of nursing staff regarding feedingtechniques and dignity during thedining process. Directed inservice for therapy regarding feeding techniques and dignity during thedining process. Directed inservicefor therapy regarding resident procedures being explained and dignity regarding body/skinexposure. All staff inserviced on explaining when providing anyassistance or conducting anyprocedure with a resident.Completion Date	

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	Resident #15, Resident #5) and for 1 of 6 residents observed in therapy. (Resident #43) Findings include: 1. On 5/10/11 at 3:45 P.M., a resident group meeting was held with the state surveyors. Seven alert and oriented residents were in attendance. The Activity Director on 5/10/11 at 3:45 P.M., indicated residents in attendance were alert oriented and reliable. Five of seven residents at this time		6/17/11DHS/Designee will monitor compliance rounds 5 times per week for 60 days and weekly thereafter, rotating between all shifts to observecall light response, diningtechniques, therapy diginity/privacy provision and procedure explanations. Call light responsewill be monitored by nursingmanagement and department heads to ensure staff responds within the established parameters. Those residents identified as using their call light will be interviewed weekly to ensurecompliance with establishedpapameters. Group interview sessions will be conductedmonthly during Resident Council to identify those residents with concerns.Results of audits and resident group sessionnotes will be reported to QA committee montly x6months and quarterly there-after for ongoing monitoring and further recommendationsif indicated.	

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	indicated call lights were answered untimely and it was a problem for them. Resident #56 indicated staff "comes in and turns off (call) light and never comes back." Resident #58 indicated at times the call light remains on for 30 minutes. Resident #61 indicated she turns on her call light and no one comes. Resident #60 indicated at times she has to wet the bed because she can't hold it. She indicated that she had to wet the bed and this had happened "couple of days ago."			

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	Resident #55 indicated she helped her roommate by turning her call light on. She indicated she told her roommate "to pee" in her bed due to no response from the call light. 2. On 5/10/11 at 7:55 A.M., residents were observed for the breakfast meal in the restorative dining room. Residents were observed being fed with staff standing over residents with multiple interruptions of feeding assistance. On 5/10/11			

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	at 8:00 A.M., Resident #5 received her breakfast tray from the Food Service Manager (FSM). Her tray was placed in front of her. (She was a resident who was fed by staff). At 8:00 A.M., Restorative CNA #1 was standing at another table feeding bites to Resident # 15 and Resident #25. Restorative CNA #1 at 8:02 A.M., left Resident #15 (a resident fed by staff) and Resident #25 (a resident fed by staff) and went to Resident #5's table and while standing over her fed her			

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	a bite. Then Restorative CNA #1 left Resident #5 and went back to Resident # 15 and #25's table and standing over them gave each of them 1 bite. Then Restorative CNA #1 left Resident #15's and 25th's table to assist an unidentified resident at a near by table. Restorative CNA #1 then returned to stand between Resident #15 and Resident #25 and give each of them a bite. Then at 8:05 A.M., Restorative CNA #1 returned to Resident #5's table and standing gave			

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	Resident #5 a bite. Then at 8:06 A.M., Restorative CNA #1 returned to Resident #15's table and gave him a drink of milk. Then at 8:07 A.M., Restorative CNA #1 indicated Resident # 25 needed repositioned in her Broda chair. Restorative CNA #1 then moved Resident #15 away from the table to the side of the table to get Resident #25 away from the table. Resident #25 was assisted out in the hall for repositioning. A few minutes later Restorative			

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	CNA #1 returned with Resident #25 and repositioned her at her table and then repositioned Resident #15 back at the same table and gave him a bite of his meal. At 8:10 A.M., CNA Restorative #1 then went to assist Resident #8 in restorative dining also. Then at 8:11 A.M., CNA #1 returned back to Resident #15 and Resident #25's table and standing gave them each a bite of their meal. At 8:12 A.M., Nursing staff #10 entered the			

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	restorative dining area and sat down by Resident #5 and began to feed her. Restorative CNA #1 pulled up a chair and sat down between Resident #25 and Resident #15 and began to feed them. 3. On 5/10/11 at 9:15 A.M., CNAs #4 and #5 indicated to Resident #5 who was up in her wheelchair with a visitor present at her bedside that they were going to assist Resident #5 to bed using a Hoyer lift. CNA #4 and CNA #5 applied			

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	straps of the lift pad to the Hoyer lift and assisted the resident to transfer from her wheelchair to her bed. The CNAs began the lift transfer of the resident from her wheelchair. While the resident was being suspended from the wheelchair the visitor at bedside explained to the resident, "going for a ride." The CNAs had not notified the resident that the lift procedure from her wheelchair to her bed was to begin. 4) On 5/10/11 at 8:20 A.M., Resident # 43 was in the Therapy Department for treatment. There were a group of five female residents seated in circular fashion			

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	doing exercises in the center of the room. The ladies were periodically conversing and were not visibly dependant. There was a male resident on the fringe of the group doing independent exercise. The Therapy Director was assisting Resident #43 in lower range of motion exercises, also on the fringe of the group. When ready to assist Resident # 43 with upper torso exercises, she was pushed through the center of the group of ladies, interrupting their occasional dialogue and taken to a table matt where the Therapy and OT Director applied a gait belt to Resident #43 and assisted her to stand. The resident's personal alarm began to sound, drawing the additional attention of two ladies from the group to the attention of one who was already observing Resident # 43. The three ladies in the group in the center of the room watched as Resident # 43, who was dependant on the two staff, was assisted to pivot, exposing her incontinent brief and bare back as her pants and shirt were not adjusted to prevent exposure. 3.1-3(t)			

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F0314 SS=D	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, record review and interview, the facility failed to provide pressure sore identification, prompt notification, treatment and complication prevention, for 1 of 5 residents reviewed for pressure sores in a sample of 12. Resident #48. Findings include:	F0314	F 314Resident #48's ulcer is currently astage 1 and has current assessmentand treatment orders in place withcareplan updated as indicated to reflect current needs with staff thatcare for him inserviced on these.Completion Date 6-17-11All residents have the potential to beaffected by the alleged deficientpractice therefore have had skin assessed to ensure interventions arein place and careplans updated. Through inservices and changes in communication procedurewill ensure that identification of areas and interventions/assessmentsare carried out timely. Also inservicing for notification, treatmentand complication prevention occurs.Completion Date 6-17-11Systemic change will include the implementation of skin impairmentcommunication form to be used bynursing and therapy when an area isidentified to give to the nurse.Completion Date 6-17-11DHS/Designee will conduct dailyrounds to ensure	06/17/2011

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	On 5/11/11 at 11:30 A.M., Resident #48 was observed have incontinence care provided by CNA#6 and OT (Occupational Therapist) #1. The resident was observed to have had an incontinent BM that had soiled a circular pressure sore which appeared to be a Stage II with an approximate 0.5 cm diameter on the inner aspect of the left buttock. CNA #6 identified the possibility of the area being a pressure sore but		that pressurereduction interventions are beingcarried out for resident #48 and a random sample of 5 residents/day x4weeks, then 3 residents/day x4 weeks,and 3/week thereafter. Skin sweep will be performed monthly by DHS/designee to determine if thereare any unaccounted for skinimpairments. Results of audit as well as full skinreport will be forwarded to the QAcommittee monthly x12 monthsand suggestions/recommendationscarried our as deemed necessaryby committee.Nursing and therapy staff will beinserviced on new communicationform as well as infecton control planof correction items listed in 441 tag.Completion Date 6-17-11	

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	indicated she did not know if the area was a pressure sore. The clinical record of Resident #48 was reviewed on 5/11/11 at 1:30 P.M. Diagnoses included but were not limited to Parkinsonism and Paralysis Agitans. The 3/25/11 Minimum Data Set Assessment (MDS) identified the resident was at risk for pressure sores. Documentation was lacking of any current pressure sores.			

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	On 5/12/11 at 9:00 A.M., RN #2 indicated she was the charge nurse on the hall where Resident #48 resided. She indicated she was unaware of any pressure sores in her hall. Documentation was lacking to indicate the possible pressure sore of Resident #48 had been reported, assessed or treated until after RN #2 was informed. On 5/12/11 at 11:10 A.M., RN #2 was observed assessing the area. Wearing gloves, she assisted CNA #5 to			

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	cleanse incontinent BM from the area. She removed the soiled gloves, failed to hand wash, and applied new gloves. To measure the pressure sore she utilized a plastic measurement window pane tool which was placed directly against the sore after the tool had been dropped and picked up off the floor. The Assistant Director of Nursing (ADON) reassessed the area as the facility Wound and Skin Nurse on 5/13/11. She			

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	documented it as a Stage II pressure sore of the left buttock, measuring 0.3 cm by 0.2 cm with a depth of less than 0.1 cm. 3.1-40(a)(2)			
F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure side rails were consistent with FDA (Food and Drug	F0323	F 323Res #5 had bed removed fromfacility and was replaced with anacceptable bed with rails that meet the regulation.Completion Date 5-10-11There were no other residentsaffected by the alleged deficient practice as stated in the 2567.Systemic change is the policy hasbeen updated to include the siderailzone measurement guidelines.Completion Date 6-17-11Monthly QA rounds by plant operations will include	06/17/2011

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	Administration) guidelines for safety regarding entrapment prevention for 1 of 4 residents reviewed for side rails in a sample of 12. Resident #5 Findings include: Resident #5's clinical record was reviewed on 5/10/11 at 1:25 P.M. Her current Minimum Data Set Assessment (MDS), dated 4/22/11, indicated a score of 4 (severe cognitive impairment), a non ambulatory status, and		review of siderails and measurement of allowed standard zones and forwarded to committee for reviewx12 months.	

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	extensive assistance of 2 or more staff for bed mobility. Her May 2011 routine physician orders included but was not limited to: an order (initiation date 4/11/11) for use of 1/2 side rails. FDA guidance documentation (5/10/11) entitled "Medical Devices and Radiation -Emitting Products" p .8: indicated, "...Summary of FDA Hospital Bed Dimensional Limit Recommendations: zone 1- within the rail <120 mm(<4 3/4"), zone 2-			

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	under the rail, between rail supports or next to a single rail support <120 mm (<4 3/4 ") ..." On 5/10/11 at 9:32 A.M., 10:10 A.M., and 3:35 P.M., Resident #5 was observed in her bed with bilateral 1/2 side rails in place. On 5/10/11 at 3:35 P.M., Resident #5 was observed in her bed with bilateral 1/2 side rails applied. The 1/2 side rails had 5 sections and each section was measured. Three of the			

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	5 sections of the side rail measured above the standard 4 and 3/4 inches between bars at 7 3/4 inches and 7 1/2 inches. On 5/10/11 at 5:50 P.M., the Administrator was made aware of the increase space between the bars of the side rails being in excess of FDA guidelines. The Administrator indicated the side rails would be removed. On 5/11/11 at 9:20 A.M., Resident #5 was			

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	observed in her bed with bilateral side rails which did not exceed more than 4 and 3/4 inches. On 5/11/11 between 11:30 A.M., and 12:00 P.M., the remaining bed rails in the facility were observed to be in the acceptable range. A current facility policy was received and reviewed on 5/17/11 at 9:22 A.M., and was entitled "Guidelines for The Use of Side Rails" (no date). The policy included but was not limited to: "...15. When side rail usage is appropriate, the facility will assess the space between the mattress and side rails to reduce the risk for entrapment..." The facility policy did not address the 4 and 3/4 inch guidelines. 3.1-45(a)(1)			
F0332 SS=D	The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, record review and	F0332	F 332Resident #38's med was retrievedfrom the back up pharmacy and given as ordered by mid afternoonand suffered no	06/17/2011

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	interview, the facility failed to ensure a medication error rate of less than 5 %. 6 Residents were observed receiving medications. 3 errors were noted for 2 residents during 2 survey days with 51 opportunities for errors in medication administration. This resulted in a medication error rate of 5.88 % . Resident # 38 and 40 Findings include: 1. On 5/10/11 at 8:15 A.M., RN # 3 indicated		ill effects.Completion Date 6-17-11Resident #40 suffered no ill effects and is now having blood pressureand pulse checked beforeadministering Norvasc and the correct strength of Voltaren gel wasobtained.Completion Date 5/11/11All residents receiving medicationhave the potential to be affected bythe alleged deficient practicetherefore when a med is unavailableand ordered daily the doctor will be notified of the 1 time change in administration time and all residents MAR's reviewed for parametersof blood pressure and pulse to beobtained before given.Completion Date 6-17-11Systemic change is that parameters of blood pressure and pulse wil be highlighted on the MAR to alert the staff to obtain these beforeadministering. Nursing staff will beinserviced on this procedure as wellas MD notification if med not givenwithin acceptable time frames.Completion Date 6-17-11.Pharmacist will perform medication pass audit monthly for 6 months withresults reported to QA.DHS/Designee will monitor 3 medication passes weekly for 2 weeks then one time weekly for one month then continue with pharmacistaudits.Results of audits will be forwardedto QA committee monthly x 6months and quarterly thereafterfor review and further suggestion.	

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	Resident # 38 was out of Amaryl. RN # 3 indicated she would order it from pharmacy and check the emergency drug supply to see if it is available to give as ordered upon rising. The physicians order, dated 6/24/10, indicated, Amaryl 1 mg (milligram) tablet, give 1 tablet by mouth every day for diabetes mellitus. The MAR (medication administration record) indicated Amaryl to be given "upon rising." 2. During medication			

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	pass observation on 5/10/11 at 8:25 A.M., RN # 3 was observed to measure the blood pressure of Resident # 40 prior to administration of the blood pressure medication, Norvasc. The nurse failed to obtain the resident's pulse prior to the administration. Review of Resident # 40's clinical record on 5/10/11 included an order for Norvasc 10 mg, give 1 tablet by mouth every morning. Hold if			

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	systolic blood pressure is less than 120 or heart rate less than 50. This order was initially written on 2/10/10. On 5/10/11 at 8:45 A.M., review of the Medication Administration Record indicated lack of obtained heart rates noted from May 1, 2011 through May 10, 2011. RN # 3 began to obtain heart rates and document them on the MAR. 3. During the medication pass observation on 5/10/11			

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	at 8:30 A.M., RN # 3 applied a topical gel, Voltaren 1%, 4 g Gram to the left shoulder and right knee of Resident # 40. The physician's orders, dated 4/18/11, was Voltaren gel 2 Gram to left shoulder and right knee 4 times a day as needed. On 5/10/11 at 9:30 A.M., the Director of Nursing was informed to the medication error for Resident # 40 and reviewed the medications from the medication cart.			

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	3.1-25(b)(9)			
F0363 SS=E	Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. Based on observation, record review and interview, the facility failed to ensure foods were prepared according to recipes and/or served according to spread sheets during 2 of 2 meals involving 6 of 6 pureed diets and 35 of 35 regular entrees served.	F0363	F 363All residents have the potential to be affected by the alleged deficient practice.Residents suffered no ill effects from the alleged deficient practice.Through corrective action and in-servicing will ensure food is prepared according to recipes and/orserved according to spreadsheets tomeet the requirement of the guideline.Completion Date 6-17-11All food prepared/served according to recipes and/or served according tospread sheets including pureed diets as well as regular entrees served.Completion Date 6/17/11All dietary cooks will be in serviced regarding preparation of food accordingto recipes and/or served according to spreadsheets for pureed and regularentrees, following recipes and portion	06/17/2011

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	Findings include: On 5/09/11 at 9:25 A.M., Cook #1 was observed preparing sauce for baked spaghetti to be served at lunch. There was no recipe present in the food prep area. She indicated she added 10 lbs. of ground beef two 6 lb. cans of pasta sauce and "about" 2 cups of water to serve 75. She indicated she usually made more to be sure to have enough because "sometimes we tend to run short in the end."		size.Completion Date 6-17-11Systemic change will include the recipeand spreadsheets will be located in the preparea and used by the cook.All foods preparedwill be according to the recipe and portion size for the pureed and entree foods. A proper size pan will be used to ensure portion size andnutritional value are prepared according to recipe.Completion Date 6-17-11Dietary Cook #1,#2 and #3 in serviced on the required location of the recipes and spreadsheetsat the prep table. Also proper size pans,scoops will be used according to the recipeto ensure nutritional values are metas required.Completion 6-17-11Executive Director/DFS/Designee will conduct rounds during meal preparations.DFS/designee will audit food being preparedserved and portioned as per recipespreadsheet x3 prep times per week,1 breakfast,1 lunch, 1 dinner x 4 weeks, then x2 prep times per week x2 weeks and x1 prep time weekly thereafter.Results of audits will be forwarded to theQA committee monthly x6 months and quarterly thereafter for review and further recommendations.	

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	The cook estimated there were as many as 35 who would choose to have the baked spaghetti entree. Review of the recipe for baked spaghetti sauce for 75 was provided on 5/12/11 at 2:45 P.M., by the Food Service Supervisor (FSS). It called for 15 lbs. of ground beef rather than 10 lbs. It called for 1 3/4 gallons plus 2 cups of canned tomato puree, 1 3/4 quart plus 1/2 cup of water, 1 2/3 Tablespoon ground thyme, 1 2/ 3			

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	Tablespoon ground basil, 1 2/3 Tablespoon oregano, 1 cup sugar, and 1 2/3 Tablespoon salt. On 5/11/11 at from 4:30 P.M. to 5:15 P.M., the food service line was observed. Cook #2 was observed serving separate portions of pureed chicken salad and pureed bread slurry for each resident to make an equivalent to a chicken salad sandwich. He used a blue scoop which he indicated was a 3 ounce portion of			

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	pureed chicken salad and "a little less full" blue scoop of pureed bread slurry "instead of the black scoop because it broke last week." He indicated he was unsure how much the black scoop held. The spread sheet tool in use for the meal indicated residents on pureed diets were to be served a 2.5 x 3.25 "piece of molded chicken salad." The corresponding recipe for the molded chicken salad directed portions of chicken salad			

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	to be equivalent to a regular diet portions which was to be pureed for each pureed diet to be served. The regular diet portion size did not specify how much chicken salad was to be included in a each sandwich, other than a serving of 1 sandwich being a serving size. The pureed chicken salad was to be layered on top of a pureed bread mix layer and covered with another layer of pureed bread mix. The pureed bread mix was made with a product			

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	called Resource Pureed Solutions Bread Mix 15 1/2 ounces to 1 1/4 Quart water rather than bread being pureed. The smallest number of servings size provided in the recipe was for 30 servings and was to be assembled in a 20 x 12 x 2 "pan in order to provide the appropriate portion size in the 2.5 x 3.25" serving. It did not address making just the 6 servings for the 6 residents on a pureed diet. Cook #2 indicated the			

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	molded pureed item recipes "have never been used so long as I have been here but we plan to go back to them." There was no recipe available for the pureed chicken salad sandwich made with scoop size portions which was served. After 4 of 6 pureed diets were served, Cook # 2 indicated he had run out and needed more pureed chicken salad for the remaining two residents. Cook# 3 made 2 more portions of pureed chicken salad sandwich			

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	by putting 2 chicken salad sandwiches in a blender with an unmeasured portion of milk to thin the consistency. She provided the mixture to Cook #2 who served a blue scoop containing the bread along with a "little less full" blue scoop of bread. The remaining 2 pureed diets served contained an unknown but predominant bread component. On 5/17/11 at 5:00 P.M., the FSS was interviewed			

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	regarding the nutritional value discrepancy between recipes made by molded puree portions and no recipes with random portion sizes. The FSS indicated the Dietician probably was not aware of method used in the facility. The FSS indicated the blue scoops contained 2 ounces rather than 3 ounces, as indicated by Cook #2. 3.1-20(i)(4)			

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	155682	A. BUILDING 00 B. WING	05/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODMONT HEALTH CAMPUS	1325 ROCKPORT RD BOONVILLE, IN47601

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F0368 SS=B	Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. Based on resident group interview and individual resident interview, the facility failed to offer bedtime snacks routinely for 7 of 7 alert, oriented, and confidential residents interviewed at the group meeting and 1 of 3 individual confidential residents interviewed.	F0368	F 368Resident #55, #56, #58, #59, #60 and#62 suffered no ill effects or weight loss from the alleged deficient practice and in the future will beoffered a bedtime snack and acceptance/refusal will bedocumented.Completion Date 6-17-11All residents have the potential to beaffected by the alleged deficient practice and will be offered abedtime snack withacceptance/refusal documented.Completion Date 6-17-11Systemic change includes dietaryand nursing inservicedregarding snack expectations,documentation of acceptance/refusaland door to door bedtime snack delivery/offer.Completion Date 6-17-11Director of food Service/designeewill monitor bedtime snack contentsdaily for 2 weeks and weekly thereafter. DHS will monitorbedtime snack	06/17/2011

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	Findings include: 1. On 5/10/11 at 3:45 P.M., a resident group meeting was held. The Activity Director, at this time, indicated the residents attending the group meeting were alert, oriented, and reliable. Seven of seven residents attending the group meeting indicated they were not routinely offered a bedtime snack. Resident #58 indicated she was not offered a bedtime snack but indicated the snacks		consumption and interview 2 residents daily for 30days, then 1xweekly for 30 days, then 1xmonthly x 6 months.Executive Director/Designee willaudit compliance through review of audits ad resident council interviews monthly.Results of all audits and resident council minutes will be forwarded to QA committee montly x6months and quarterly thereafterfor review and furtherrecommendations.	

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	were out in the hall. She indicated she was not routinely offered any snacks. Resident #60 indicated snack times were 10:00 A.M., 3:00 P.M., and 8:00 P.M. She indicated if your not up you miss out. Resident #55 indicated she frequently tries to obtain snacks from the hall for Resident #56 and #59. 2. On 5/12/11 at 2:55 P.M., during confidential interview Resident# 62 was interviewed regarding bedtime snacks.			

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	Resident #62 indicated staff does not routinely come to her room and offer bedtime snacks but bedtime snacks were available in the hall area. 3.1-21(e)			
F0371 SS=F	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review and interview, the facility failed to ensure sanitary practices and/or surfaces to prepare, serve, and store food during 4 of 4 observations of the	F0371	F 371All residents have the potentialto be affected by the allegeddeficient practice.Residents suffered no ill effectsfrom the alleged deficient practiceand through corrective actionand inservicing will ensure sanitarypractices and or surfaces to prepareserve and store food are followedas guidlines require.Completion Date 6-17-11Dietary Staff inserviced on requirement of Quaternary sanitizer test and of sanitary practices regarding the correct method of using test strips to ensure the solution strength is at	06/17/2011

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	kitchen which serviced all residents. Findings include: 1. On 5/09/11 at 9:00 A.M., Cook #1 attempted to test the Quat solution being used to sanitize food contact surfaces. She dipped the test strip in the solution without timing its submersion in the solution, for approximately 5 seconds. She indicated the test strip was supposed to be dipped for 60 seconds before		required levels.Completion Date 6-17-11Handplates on the front and backof the main kitchen door cleaned removing the hand soil and dried food.Completion Date 5-9-11The undated/outdated packages of processed meat found in the walkin refrigerator were discarded.Completion Date 5-9-11The employee tote bag stored on a shelf in the walk in refrigeratorwas removed.5-9-11The ice machine was cleaned and the slime consistency material was removed as well as the spots of black matter along the front.Completion Date 5-9-11The stove knobs and door and one microwave soiled with oily brown matter were cleaned to ensuresanitary condition.5-9-11All dietary staff inservice ont he sanitation requirements for the kitchen to ensure sanitationguidelines are followed at all times.Completion Date 6-17-11Cook #2 direct inservice regarding proper washing of fruits before serving to ensure prewashing offruits are completed to meet sanitary requirements.Completion Date 6-17-11CNA#5 direct inservice regarding proper procedure to be followed regarding proper use of hairnetswhen in food prep area, also regarding bringingpersonal items in kitchen such as lunch tote and food.Through corrective action and inservice of CNA#5and all staff inservice on	

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	comparing the color to the chart to determine the strength of the solution. The Food Service Supervisor (FSS) indicated the correct method was to dip the strip for 60 seconds. The manufacturer's directions indicated the test strip was to be dipped for 10 seconds. Cook #1 stated "If hold it longer I'd get better color." When the test was then completed correctly the solution was 200 ppm. On 5/11/11 at 9:30 A.M.,		proper sanitation procedures the kitchen.Completion Date 6-17-11Restoratve CNA#1 direct inservice on sanitation procedures regarding hairnets, uniformstouching food prep table to ensure sanitary conditions are maintained in food prep areas.Completion Date 6-17-11Executive Director/Designee will audit sanitation check list completed by the Food Service Director/designeex2weekly for 30 days, x1weekly thereafter.Completion Date 6-17-11Results of audits will be forwarded to QA committee monthly x6 months and quarterly thereafter for review and further recommendations.	

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	Dietary Assistant (DA) #1 performed the Quat solution test by holding the tape in the solution for 8 seconds. She stated "you hold it in about 3 seconds." When informed by the FSS it should be 10 seconds she held the tape in for 3-4 seconds without timing it. She indicated the tape had been held in for 10 seconds because she had counted to 10 in her head. When asked to do the count aloud, she counted to 10 in under 4 seconds. At 10 seconds the solution compared to			

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	the chart was 200 ppm. The undated facility Quaternary Sanitizer Test Procedure indicated the test strip should be dipped and compared to the color chart at 10 seconds to determine a required solution strength of 150-300 pp. 2. On 5/09/11 at 9:15 A.M., the hand plates on the front and back of the main kitchen door were heavily soiled with a tacky accumulation of hand soil and spattered dried food . The door			

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	was utilized by dietary and nursing staff, for entry and exit from the kitchen to serve meals and collect soiled dishes. The ice machine had an accumulation of an opaque slime consistency material along the white plastic guide across the interior of the ice cabinet. The white plastic also had several B-B sized spots of black matter appearing as mildew growth along the front. There were 4 of 8 packages of processed			

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	meat stored in the walk in refrigerator that were outdated or improperly labeled to determine discard dates. These included an undated package of smoked turkey slices, an undated package of bologna, an undated package of diced ham, and 3 hot dogs, dated 3/30. On 5/17/11 at 10:40 A.M., a Policy and Procedure, dated 2009, indicated "Refrigerated items that are open must be discarded within 7 days. There was an employee			

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	tote bag, brought from outside the facility, stored on a shelf in the walk in refrigerator with the processed meats above. The FSS indicated the personal tote contained an employee's insulin. The stove knobs and door as well as 1 of 2 microwaves were heavily soiled with visible accumulation of oily, brown matter, causing surfaces to be tacky to touch. 3. On 5/11/11 at 3:30			

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	P.M., Cook #2 was observed preparing a serving platter of cut fruits. He had an original commercial vented plastic delivery container of strawberries on the food prep counter. He was removing unwashed fresh strawberries, with green leave caps intact, and placing them on trays. He indicated he had thought berries were commercially pre washed. He checked the container label which did not identify product as pre washed.			

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	On 5/12/11 at 11:00 A.M., CNA #5 was observed in the kitchen without a hairnet working on a food prep counter. She had opened her personal lunch tote on the counter, opened her sandwich and was adding mustard from a squeeze bottle provided to her by dietary staff.. On 5/17 11 at 11:30 A.M., Restorative CNA #1 was observed in the kitchen without a hairnet working on a food prep counter where iced			

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	beverage trays had been placed. Her nursing care uniform was rubbing against the counter as she opened a carton of chocolate milk and poured it into a double handled sippy cup. She indicated this was her routine assignment to prepare drinks for certain residents. On 5/17/11 at 12:30 P.M., the 2009 Dress Code and personal hygiene policy was reviewed. It directed "Employees will wear hairnets that			

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	COMPLETELY covers the hair while in the kitchen or serving food....No personal items, such as purses and coats may be placed in the food preparation, service and storage areas." 3.1-21(i)(1)			

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F0425 SS=A	The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation and interview, the facility failed to ensure that unused portions of discontinued medications were destroyed within 7 days for 3 of 4 discharged residents. Resident # 51, # 53, # 54	F0425	F 425Discharged res #51's Dulcolaxsuppositories were disposed of.Completion Date 5-12-11Discharged res #53's Dulcolaxsuppositories were disposed of.Completion Date 5-12-11Discharged res #54's Phenergansuppositories were disposed of.Completion Date 5-12-11There were no other residents affected by the alleged deficient practice and through alterations in processes and inservicing will ensure correct actionsto capture disposition of medication in a timely fashion.Completion Date 6-17-11Nursing staff will be inserviced on proper procedure and documentation of disposition of discontinuedmedications including refrigeratedmeds.Completion	06/17/2011

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	Findings include: On 5/12/11 at 9:30 A.M., the medication refrigerator included medications for 3 residents with whom were discharged from the unit. Resident # 51, was discharged 3/29/11. There were 4 Dulcolax 10 mg suppositories in the refrigerator. Resident # 53 was discharged 4/2/11. There were 5 Dulcolax 10 mg suppositories in the refrigerator. Resident # 54 was		Date 6/17/11Medical Records will conduct postmed discontinuation chart audits on10 random meds per month and all discharged residents to ensuredocumentation is complete and immediate attention to ensure the disposition is complete within the 7 day requirement.Completed audits will be forwardedto QA committee monthly x6 monthsand quarterly thereafter.	

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	discharged 3/13/11. There were 6 Phenergan 12.5 mg suppositories in the refrigerator. On 5/16/11 at 10:52 A.M., record review of the policy and procedure was received from the Director of Health Services that indicated, "Medications will be destroyed within 7 days of discontinuing or discharge by two licensed nurses or the Pharmacy Consultant and one licensed nurse." On 5/16/11 at 1:00 P.M.,			

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	an interview with the Director of Health Services indicated the policy was also used for all medications in item # 2 of the guidelines for disposal of controlled drugs. 3.1-25(r)			

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F0431 SS=E	The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review the facility failed to monitor/maintain proper medication	F0431	F 431Res #1, #2,#3,#4,#7,#11,#17,#23#26,#36, #37,#38,#39,#40,#43,#52and #54's meds wer disposed of and reordered with no ill effects suffered by these residents as the meds werenot used.Completion Date 5-12-11There were no other residents affected by the alleged deficient practice and through	06/17/2011

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	refrigerator temperatures for 1 of 1 medication room refrigerator affecting 15 of 48 residents, 2 discharged residents, facility house supply medications, an emergency drug kit for controlled medications and an emergency kit for refrigerated medication items. Resident # 1, # 2, # 3, # 4, # 7, # 11, # 17, # 23, # 26, # 36, # 37, # 38, # 39, # 40, # 43, # 52, # 54 Finding include:		implementation of a temperature log with identified parameters of acceptable temperatureand inservicing will prevent refrigerator from being outside acceptable range.Completion Date 6-17-11Nursing staff will be inserviced on appropriate refrigerator temperaturesand the log that is available for dailyentries.Completion Date 6-17-11DHS/Designee will reviewtemperture log daily x2 weeks,2x/week for 6 weeks and weekly thereafter.Completed logs will be brought toQA committee montly x12months for review and to ensurecompliance with requirement.	

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	On 5/12/11 at 9:30 A.M., the medication refrigerator was observed to be 21 degrees Fahrenheit. RN # 2 observed the thermometer to read 21 degrees Fahrenheit. The Unit Manager indicated she would pull labels for reordering on medications that indicated "do not freeze." At 1:35 P.M., on 5/12/11, during observation with the Director of Health Services the medication			

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	refrigerator was 29 degrees Fahrenheit. A blank refrigerator check form for May 2011 was taped to the front of the refrigerator door. The Director of Health Services indicated she would,"get a refrigerator log." Medications included in the refrigerator at a temperature of 21 degrees Fahrenheit labeled "do not freeze" included: Resident # 1, 6 acetaminophen 650 mg suppositories			

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	Resident # 2, 8 acetaminophen 650 mg suppositories Resident # 3, 12 acetaminophen 650 mg suppositories Resident # 4, 5 phenergan 25 mg suppositories, 2 - 1 milliliter vials of aranesp 25 mcg/ml Resident # 7, 5 acetaminophen 650 mg suppositories Resident # 11, 8 acetaminophen 650 mg suppositories, 6 phenergan 25 mg suppositories Resident # 17, 5			

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	phenergan 25 mg suppositories Resident # 23, 5 phenergan 25 mg suppositories Resident # 26, 5 acetaminophen 650 mg suppositories Resident # 36, acetaminophen 650 mg suppositories Resident # 37, acetaminophen 650 mg suppositories Resident # 38, 8 acetaminophen 650 mg suppositories Resident # 39, 6 phenergan 25 mg suppositories			

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	Resident # 40, 6 phenergan 25 mg suppositories Resident # 43, 6 phenergan 25 mg suppositories, phenergan 12.5 mg suppositories and 6 acetaminophen 650 mg suppositories Resident # 52, 3 phenergan 25 mg suppositories Resident # 54, 6 phenergan 12.5 mg suppositories House supply: Influenza virus vaccine, 1- 3/4 of a 5 ml vial, 5 unopened 5 ml vial			

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	Pneumococcal vaccine, 1-5 dose vial, unopened Engerix B 20 mcg/msyr 1 DO, 4 injectable /4 doses and 1 ml vial Tuberculin Purified Protein, 2- 1/2 vials opened and 3 unopened vials Emergency kits included: 4 phenergan 25 mg suppositories and 4 acetaminophen 650 mg suppositories On 5/13/11 at 9:10 A.M., the facility Medication Storage Policy and Procedure was reviewed.			

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	Item J indicated, "Medications requiring "refrigeration" or "temperatures between 2 degrees Celsius (36 degrees Fahrenheit) and 8 degrees Celsius (46 degrees Fahrenheit)" are kept in a refrigerator with a thermometer to allow temperature monitoring. Medications requiring storage "in a cool place" are refrigerated unless otherwise directed on the label." 3.1-25(m)			

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F0441 SS=E	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, and interview, the facility failed to ensure	F0441	F 441Res #6,#7 and #8 suffered no ill effects from the findings on the 2567related to water pitchers and strawsand through alteration in fresh waterpassing will prevent crosscontamination.Completion	06/17/2011

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	practices to prevent transmission of infection between residents during medication administrations, water passes, treatments/procedures and therapies involving 3 of 3 units. These practices affected Resident # 6, #7, #8 # 48 #43, #46, #47, & #36) and involved CNA # 4, RN # 2, OT # 1, RN # 3 Findings include: 1. One of 3 staff observed passing water from room to room		Date 6/17/11Res #48 suffered no ill effects and through corrective actions and inservices including CNA#5 and RN#2will ensure that resident careand handwashing procedures arecarried out to prevent possiblecontamination.Completio n Date 6-17-11Res #43,#46, and #47 suffered no ill effects and through corrective actionand inservicing of Occupational therpist #1 and all therapy staff onhandwashing/hand sanitizer use.Completion Date 6-17-11RN#3 will have directed inservice with infection control procedures,observation of med pass and treatments for infection controlprocedures and handwashing, glovingand sanitizer use.Completion Date 6-17-11All residents have the potential to be affected by the alleged deficient practice and through alterations in processes and inservicing will ensurecorrective actions to prevent spread ofinfection are followed,Completion Date 6-17-11Systemic change for fresh water passwill be passing new pitchers with each pass instead of refilling andnursing staff inserviced on procedure.Nursing staff will be inserviced onproper handwashing and glove usage procedures to preventspreading of infection.Nursing staff will have return demostration of skills to prevent infection including handwashing and glove	

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	failed to follow practices to prevent cross contamination between residents. On 5/10/11 at 10:30 A.M., CNA #4 was observed passing ice and providing fresh water from room to room, in sequence, down the hall. She entered the room of Resident # 6 on the 100 unit, handled the soiled water pitcher and contacted the soiled straw on with her hand as she removed the lid. She emptied the old water and replaced some of it with fresh. She took the soiled pitcher to		application/changing as well assanitizing procedures. Skills will bere-evaluated on an annual basis for competency.Completion Date 6-17-11DHS/Designee will monitor residentcare that includeshandwashing/glove usage after careand techniques of all care provided5xweek for 3 weeks, 3xweek for 2 months and then weekly.Results of audits will be forwardedto QA committee monthly x6 months and quarterly thereafterfor review and furthersuggestions/comments.	

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	the water pass cart, scooped ice into the pitcher and replaced the lid. She arranged the level of the soiled straw in the pitcher as she replaced the lid. She went next in sequence to Resident #7 and Resident #8 without hand sanitizing, performed the same procedure in the same way with the same contamination problems for the water supply of each resident. 2. On 5/12/11 at 11:10 A.M., RN #2 was			

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	observed assessing a pressure sore, the area on the left buttock of Resident # 48 on the 300 unit. Wearing gloves, she assisted CNA #5 to cleanse incontinent BM from the area. She removed the soiled gloves, failed to hand wash, and applied new gloves. To measure the pressure sore she utilized a plastic measurement window pane tool which she placed directly against the sore after the tool had been dropped and picked up off the floor.			

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	3. On 5/10/11 from 8:30 A.M. to 9:00 A.M., Occupational Therapist #1 was observed working with and assisting residents in the Therapy department. She failed to sanitize hands between contacts with: Resident #43 whom she assisted to transfer, contacting her incontinence brief and stroking her long hair, Resident # 46 whose hands and shoulder she touched , and Resident #47 whom she set up with overhead			

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	pulley exercises after storing multi person use exercise equipment and, reaching in her pockets to find and apply personal lip gloss. On 5/12/11 at 10:30 A.M., the Therapy Director indicated therapy staff were inserviced and expected to hand sanitize between resident contacts. There was a sink for handwashing and hand sanitizer available in a wall dispenser for staff use. 4. During medication pass observations			

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	on the 220 unit, the following was noted: On 5/10/11 at 8:15 A.M., RN # 3 was preparing to fix medications for Resident # 40's morning medications. In observing for handwashing, the RN did not indicate verbally that she had washed her hands nor was it observed before starting to prepare the medications. On 5/10/11 at 8:20 A.M., RN # 3 noted an alarm sounding, locked her medication cart to respond to the alarm. RN # 3 entered Room 203, silenced the alarm and returned to the medication cart to resume fixing Resident # 40's without using alcohol gel or washing her hands. On 5/11/11 at 11:3 0 A.M., RN # 3 was passing medications performing accuchecks and administering insulins as ordered. RN # 3 completed the procedures. Upon returning to the clean medication cart to dispose of the used items, RN # 3 raised the lid to the trash bin using her un-gloved hand to dispose of the waste items. She then began continuing the medicine pass. On 5/11/11 at 11:47 A.M., RN # 3 completed an accucheck and cleansed the glucometer with a Clorox disinfecting wipe and then using the same Clorox wipe, wiped her hands using a cleansing motion (as if applying lotion to her hands,			

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	one hand wiping the other). On 5/11/11 at 1200 noon, RN # 3 proceeded to obtain an accucheck on Resident # 36. After wiping a finger with an alcohol prep, the RN blew on the resident's finger to dry the alcohol before using the lancet to obtain the blood sample. 3.1-18(b)(1)			
F0502 SS=D	The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. Based on interview and record review, the facility failed to obtain a timely PT/INR(Protime International Normalized Ratio lab test) for 1 of 3 residents reviewed for receiving the medication, Coumadin (anticoagulant medication) in a sample of 12. Resident #32	F0502	F 502Res#32 has current anticoagulanttherapy orders and labs clarified and licensed nurses that care for her havebeen inserviced on these orders and through corrective action will ensurethat monitoring is done according to physician	06/17/2011

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	Findings include: Resident #32's clinical record was reviewed on 512/11 at 10:15 A.M. Her current May 2011 routine physician orders included but were not limited to: Coumadin 2 mg- give 1 tablet with 2.5 mg = 4.5 mg orally every Sunday, Monday, Thursday, and Saturday. Coumadin 2.5 mg give 1 tablet with 2 mg =4.5 mg orally every Sunday, Monday, Thursday, and Saturday. Coumadin 3 mg give 1 tablet orally every Tuesday, Wednesday, and Friday. A lab report, dated 5/2/11, indicated PT-18.6 (H)(high) reference range seconds(10.5-12.5) and INR-2.23(H) (high) ratio reference range (0.90-1.10). A physician telephone order, dated 5/2/11, indicated, "continue same dose Coumadin re check PT/INR on 5/9/11." Documentation was lacking of a PT/INR lab test due on 5/9/11. A telephone order, dated 5/10/11 at 11:20 A.M., indicated, "Stat (immediately) PT/INR d/t (due to) not obtained on 5-9 results needed." A telephone order, dated 5/10/11 at 4:00		orders.Completion Date 6-17-11All residents receiving anticoagulanttherapy have the potential to beaffected by the alleged deficient practice therefore DHS/designee hasreviewed their medications and labsand lab monitoring orders.Completion Date 6-17-11Systemic change is that residents receiving anticoagulant therapy willhave lab results available to facilitybefore med is due for administration.Licensed nurses will be inserviced on new procedures and thatanticoagulant is not to beadministered wthout lab documented.Completion Date 6/17/11DHS/Designee will monitor MARS and lab flowsheets five times per week for 30 days then weekly for 90days and monthly thereafter to ensure timely labs are obtained.Results from audits will be forwarded to QA committee monthly x6 months and quarterlythereafter for review and furthersuggestion.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155682	A. BUILDING 00 B. WING	05/18/2011

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	P.M., indicated to continue same dose of Coumadin and recheck PT/INR on 5/19/11. On 5/12/11 at 11:10 A.M., during interview with the Director of Nursing (DON) she indicated the 5/9/11, PT/INR lab test was not obtained as ordered. 3.1-49(a)			
F0518 SS=D	The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. Based on interview and record review, the facility failed to ensure 1 of 3 staff members interviewed was able to verbally explain the facility's emergency procedure related to	F0518	F 518All residents have the potential tobe affected by the alleged deficient practice.Residents suffered no ill effects fromthe alleged deficient practice.Through corrective action and inservicing will ensure that safety ofall residents is maintained.Completion Date 6-17-11Laundress#1 directly inservicedon Emergency procedures related to fire/safety according to interpretiveguidelines as it relates to fire/safety toensure the safety of residents.Completion Date 5-11-11All Staff inserviced on fire/safety guidelinesto ensure the	06/17/2011

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	fire in a dryer in the laundry room. This had the potential to affect the safety of all residents in the facility. (Laundress#1) Findings include: On 5/11/11 at 3:30 P.M., during an interview with Laundress # 1, she was unable to identify how to respond if a fire were to break out in one of the 3 dryers in the laundry		safety of all residents is main-tained.Completion Date 6-17-11Director of Plant Operations/designess willaudit all fire drill/inservices to ensure that laundry staff is responding and signing the sign in sheets when fire drills/inservices areconducted. x1 per month x6 months and quarterly thereafter.Results of fire drill/inservice will be forwardedto QA committee monthly for six months and quarterly thereafter.	

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	department. A non-verbal response of side to side head motion indicated a "no answer" response. On 5/11/11 at 4:05 P.M., during an interview with the Administrator, she indicated that Laundress # 1 had been employed for 10 years and was sure she had attended inservices and drills and could remember her attendance at the inservices and drills.			

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	On 5/16/11 at 9:30 A.M., a record review of the inservice "Fire Drill Attendance Roster" indicated Laundress # 1 had attended the last inservice and drill on 4/28/10. 3.1-51(b)			